

DOCUMENT RESUME

ED 278 891

CG 019 669

TITLE Report and Recommendations on Adolescent Pregnancy in Mississippi.

INSTITUTION Mississippi Governor's Office of Federal-State Programs, Jackson.

PUB DATE Jul 86

NOTE 37p.; Developed by the Adolescent Pregnancy Task Force.

PUB TYPE Reports - General (140)

EDRS PRICE MF01/PC02 Plus Postage.

DESCRIPTORS *Adolescents; Community Role; *Early Parenthood; Education; Family Role; Health; High Risk Persons; *Human Services; Individual Needs; *Pregnancy; *Prevention; Social Support Groups; State Programs

IDENTIFIERS *Mississippi

ABSTRACT

This document contains the conclusions and recommendations of a task force established to review the status of adolescent pregnancy and childbearing in Mississippi and to make recommendations for programs and policies that would serve to prevent or lessen the negative impact of adolescent pregnancy. The introduction of the report presents statistics on adolescent pregnancies nationally and in Mississippi. The next section examines the economic impact of teenage pregnancy. Task force findings and recommendations are provided in five sections: (1) family and youth awareness; (2) community awareness; (3) health; (4) education; and (5) support services. A summary notes that services currently offered to at-risk teenagers, pregnant teenagers, and parenting teenagers are inadequate and unevenly distributed in the state and that there is no network for existing programs to exchange information. The report calls for a core service support system which would work to identify at-risk adolescents; provide services to at-risk, pregnant, and parenting adolescents and their families; and provide complete services for life planning through a case management approach. Data tables illustrate the 1984 teenage pregnancy rate by county and provide information on low birth weight babies, out-of-wedlock births, prenatal care, and teenage births by age and race. (NB)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

REPORT ON ADOLESCENT PREGNANCY IN MISSISSIPPI

July 1986

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

- ☒ This document has been reproduced as received from the person or organization originating it.
- ☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

Nellie B. Hutchinson

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

**REPORT AND RECOMMENDATIONS
ON ADOLESCENT PREGNANCY IN MISSISSIPPI**

**Developed by the Adolescent Pregnancy Task Force
of the
Commission for Children and Youth**

**Department of Human Development
Governor's Office of Federal-State Programs**

July 1986

Table of Contents

	Page
Acknowledgments	
Executive Summary	1
Introduction	4
Economic Impact	7
Teenage Pregnancy Rate by County, 1984	9
I. Family and Youth Awareness	10
II. Community Awareness	12
III. Health	14
IV. Education	17
V. Support Services	20
VI. Summary	23
Bibliography	24
Charts	
1983 Percentages of Low Birth Weight Babies	26
1983 Percentages of Teen Births Out-of-Wedlock	27
1983 Percentages of All Out-of-Wedlock Babies Born To Teens	27
1983 Percentages of Women Receiving Early Prenatal Care	28
1983 Percentages of Women Receiving Late or No Prenatal Care	29
1983 Percentages of Low Birth Weight to Teens	30
1984 Teen Births by Age and Race	31
Adolescent Pregnancy Task Force Members	32



Acknowledgment

REPORT AND RECOMMENDATIONS ON ADOLESCENT PREGNANCY IN MISSISSIPPI

Bill Allain, Governor
Governor's Office of Federal-State Programs
Beverly W. Hogan, Executive Director
Department of Human Development
Michael Raff, Director
Commission for Children and Youth
Nellie Hutchison, Director
Adolescent Pregnancy Task Force
Martha Stennis, Chair

Research/Editing:	Linda Ross Aldy Commission for Children and Youth
Introduction:	Geraldine Brookins, Ph.D.
Economic Impact:	Paul Jones, Ph.D.

For additional information, contact:
Commission for Children and Youth
301 West Pearl Street
Jackson, Mississippi 39203-3093
Telephone: (601) 949-2009

Executive Summary

Adolescent pregnancy has always been a problem in Mississippi, but has only recently been recognized as one with significant implications for the present and future in terms of economics and human development. Dramatic impact exists for, not only the individual teen and her family, but for every member of society. As we have come to realize the loss of human potential to our society resulting from our high rate of adolescent pregnancy, it is clear that the problem demands immediate commitment and action. Individuals and families, public and private agencies, civic and community organizations, religious groups, business and labor, and state and local governments must unite for effective confrontation of adolescent pregnancy and its problems.

More than 21 percent of all Mississippi's babies are born to adolescents. We continue to have one of the highest rates of teen pregnancy in the nation. The severity of this number is emphasized by the comparison with the national rate of 13.7 percent.

Adolescent pregnancy is costly to Mississippi in both human and fiscal terms. In 1985, 355 out-of-wedlock babies were born to adolescents under the age of 15 and 5,693 out-of-wedlock babies were born to teens aged 15 to 19 years. Another 3,000 babies were born to married teens in 1985. Babies born to teenagers are twice as likely to die before their first birthday as babies born to mothers aged 20 through 29. In 1985, the infant mortality rate was 13.7 deaths per 1,000 live births. It is estimated that three times the number of babies who die live with permanently handicapping conditions, many of which could have been prevented. It costs the state an estimated \$955,550 to provide a lifetime of care for one severely handicapped child.

Adolescent or teen parents are more likely to need and receive public assistance at an

estimated cost of \$332 million in 1984 while the first baby of a teen mother receiving public assistance is estimated to receive a total of \$15,620 from the state prior to age 20.

While it is hard to place a dollar amount on the cost of a girl dropping out of school, comparisons in income levels between those girls with a four-year high school education and those who did not complete high school show that the dropouts earn an average of \$2,608 less annually. During the 1984-85 school year, 432 Mississippi girls gave pregnancy as the reason they quit school. Using these figures, it can be projected that the pregnant girl who drops out of school and never returns will earn \$127,792 less over an estimated 49 years of working. Projecting the lifetime reduced income by the 432 girls who dropped out of school due to pregnancy, the state is facing a potential reduction in tax base of more than \$55 million for that one year's dropouts or an estimated \$5.06 million in revenues to the state's general fund.

The emotional consequences of premature pregnancy include such factors as higher divorce rate for those pregnant teens who do marry before the baby is born, a higher rate of suicide and attempted suicide and a higher rate of child abuse and/or neglect. An adolescent pregnancy forces an adolescent to make decisions for herself and for the future of her baby before she is emotionally ready to make those decisions. The pregnancy strains even the best of family relationships and increases the level of stress with which all family members must cope. Additionally, studies have shown that the babies of teen parents are likely to have problems adjusting to school and often demonstrate behavioral disorders and are more likely to have lower intelligence quotients and to repeat at least one grade in school. These children also demonstrate hostility, are easily frustrated and may be uncommunicative and

overly conforming. The studies point out that additional factors such as poverty, low birth weight and poor nutrition may also be contributors to these problems.

The task force, through a study of five major areas affecting adolescents, has drawn conclusions and made recommendations which are essential to ameliorating the problem of adolescent pregnancy in Mississippi.

The family is an essential component in addressing this problem and parent/child communication is a necessity. Parents must educate themselves to understand the developmental stages of their children, particularly the adolescent period. They must increase their communication skills through available resources and acknowledge the need for open communication in their families. Parents must also accept and act on the responsibility to instill values, to develop positive self-esteem, and to teach rational decision-making skills to their children. They must teach both their sons and daughters equal responsibility for the consequences of sexual activity.

Each of us must accept responsibility as a citizen of our community and all components of the community must work together for enhancing all families' abilities to meet their responsibilities toward their children. Communities must develop strategies to help teens learn to take responsibility for their future by giving them reasons to accept responsibility and reasons to dream about their future. Expanded opportunities for career and educational choices, strengthened decision-making skills, rewarded hard work and encouragement of responsible behavior must also be included in these community strategies.

The interrelated emotional and physical health needs of the pregnant teen and her baby must be met. The families involved in these lives must also be included. Pregnant teens have

special needs which must be addressed by all systems, particularly health and education, which are responsible for programs affecting teens. Programs should be comprehensive and include counseling for life planning. Proper attention to the baby's needs in the prenatal period, at delivery and after must be stressed to the adolescent parent by the systems with which the mother and baby will be in contact. The mother must understand that her actions during pregnancy and as a parent will shape her baby's future.

Since schools have the greatest amount of time and contact with the children of our state, their efforts must be directed toward providing needed alternatives to prevent dropouts, to provide specialized career development programs, and to teach parenting skills as well as family life education in a realistic manner.

There is a severe shortage of comprehensive programs in Mississippi directed toward the special needs of adolescents and teens. Comprehensive planning among public and private agencies and professional health organizations must be coordinated to address the short-term and long-range needs of adolescents for postponement of sexual activity, for prevention of pregnancy among those who are sexually active and services for those who are pregnant and/or parents and their children. Coordination and planning should include the business community leaders and should address such specific areas as comprehensive health clinics and/or school nurses, nutrition programs, financial and medical assistance, as well as the day care needs of teen parents.

This report offers a wide range of activities for everyone — from an individual commitment to collective coordination and planning; from enhancing the family role to activating groups who may not have considered themselves as part of the solution. The task force, through

research and through personal involvement and observation, understands that adolescent pregnancy in Mississippi cannot be addressed as a problem in itself. The issues of poverty, education, employment opportunities, parenting skills and life planning options must be considered also.

No one of us alone can make the needed changes or take the needed steps to ameliorate this problem, but together we can work to reduce the rate of adolescent pregnancy and the problems associated with it.

We have proposed a number of activities and programs designed to create a better future for adolescents, for children born to adolescents,

and therefore, to create a better future for all of us. Some of these proposals will require strong support by the Governor and/or the various executive agencies which may have responsibility for them. Some will require funding for start-up, expansion and operation which will necessitate legislative cooperation and county and municipality commitment.

All will require that we, individually and collectively, recognize the seriousness of the problem for us both now and for the future.

Leadership will have to be provided from all arenas and from all levels if Mississippi is to break the disruptive cycle of children having children.

Introduction

In 1982, over one-half million babies were born to teenagers in the United States. Nationally, adolescent pregnancy and childbearing have emerged as a problem of enormous proportions. This has significant implications for the well-being of almost all facets of our society, including the economic, health and educational status of the general population. Indeed, the current trends in adolescent pregnancy, childbearing and parenting have the potential of exacerbating the future problems of our society by creating a substantial population steeped in poverty, characterized by congenital health problems, minimally educated, and serving as a drain rather than contributor to all other economic, human and natural resources.

Mississippi contributes substantially to this national scene. In 1984, 9,298 or 21.2 percent of all live births were to mothers under the age of twenty compared to 13.7 percent nationally. Of these teen births, 66.1 percent were out-of-wedlock as compared to 43.7 percent nationally.

These data reflect a number of problems for Mississippi. On the individual level, they indicate that many of these teens have foreclosed an array of life opportunities for themselves and their offspring. Moreover, they indicate that the natural flow of the human developmental cycle has been interrupted and life planning for and by these teens has been disjunctive and ill-informed. On a community level, the data reflect an absence of consensus regarding how to acknowledge and subsequently address the problem. At the state level, these statistics suggest that resources, both economic and human, have had to be directed toward maintenance and rehabilitation rather than toward prevention of teenage pregnancy and the forward development of the youth of our state.

Formation of the Task Force

In 1984, for the above reasons and others, in-

cluding encouragement from various constituents within the general public, the Commission for Children and Youth, Governor's Office of Federal-State Programs, established a task force to review the status of adolescent pregnancy and childbearing in Mississippi and to make recommendations for programs and policies that would serve to prevent and/or lessen the problem's negative impact. Accordingly, representatives from state agencies, educational institutions, the medical profession, local civic organizations, advocacy groups, programs for pregnant and parenting teens and religious groups were appointed to serve on the task force. The task force was chaired by Martha Stennis, who also serves on the Commission for Children and Youth. While all members had input into the process, the task force was organized into four sub-committees, addressing the following areas:

Public Awareness sought to determine how well-informed the community was about the issue and ways to improve public knowledge;

Education sought to determine the current status of comprehensive health education within the schools, ways to further implement such programs, and to provide ongoing education to youth and the general public;

Health sought to determine the health status of childbearing teens and their babies and suggest ways to improve the status;

Economic Impact sought to determine the impact of teen pregnancy and childbearing on the economic well-being of the state and recommend ways to minimize the negative impacts.

Task Force Assumptions

The members of the task force held a diversity of opinions, beliefs and presumptions. However,

they shared a commonality of concern for the welfare of Mississippi's children and families. From this commonality, several basic assumptions were identified as fundamental to task force deliberations:

- Children should not have children;
- Adolescents should not be sexually active outside of marriage;
- Adolescents should be informed of the consequences of being sexually active outside of marriage;
- Adolescent parents should be provided with appropriate information regarding parenting and child care;
- Adolescents have complex health and social services needs which require unique and highly specialized services;
- Adolescent parents should be provided with counseling and education supportive of delaying subsequent pregnancies.

The task force recognizes and supports the primacy of the family in the socialization of children, and thus, directed its efforts toward suggesting programs, policies and community activities that complement the central role of the family in the development and life planning of all youth.

Adolescent Pregnancy

There are a number of myths that surround teen pregnancy. It is commonly believed that only the poor and minorities get pregnant during adolescence. Some believe that teens in Mississippi become pregnant in order to receive welfare benefits. The facts, however, are contrary to these commonly held beliefs. Adolescent pregnancy occurs among all socio-economic strata and racial and ethnic groups. Nationally the pregnancy rate for black teens is decreasing while it is increasing for white teens. Studies from other states with more liberal

welfare benefits affirm that teen pregnancy rates are not tied to the amount of benefits available. The welfare "benefits" in Mississippi are such that they would hardly serve as a motivator for a lifetime commitment resulting from pregnancy, childbirth and parenting.

Adolescent pregnancy occurs among all socio-economic strata and racial and ethnic groups.

Adolescent pregnancy is diverse, complex and controversial. The task force recognizes that the ramifications of pregnancy and childbearing are probably different for an unmarried 13 year-old and a married 18 year-old; for a teen having her first baby and one embarking on her third child; for a black adolescent versus a white adolescent. It further recognizes that male and female teens approach sexuality from a variety of perspectives ranging from abstinence to frequent sexual activity with little or no understanding of consequences. The task force takes as given that no one program, policy or activity could address such a multifaceted issue.

The task force also recognizes that adolescents today receive conflicting messages regarding the role of human sexuality in their lives. The media and business advertising capitalize on sex as a subliminal motivator for buying products, attaining popularity and maintaining self-esteem while the societal/family value views adolescent sexuality as inappropriate.

Adolescence is a time of natural turbulence. It is a period in the developmental cycle when the individual is charged with the task of sorting out one's identity, coming to grips with one's self-worth and self-esteem, and importantly one's self control and ability to delay certain gratifications until later in life. This is also a

time when all of those qualities are very difficult to achieve, due in part, to maturational changes over which the teens have no control, and also due to the naturally emerging separation process characteristic of adolescence. The child is attempting to establish an identity separate and distinct from his or her parents. Oftentimes this separation process takes the form of conflict with values, attitudes and activities sanctioned by the parents. Unfortunately, sexual activity is sometimes used as a demonstration of rebellion or as the adolescent's pretense of adulthood.

The task force does not suggest a single cause for early sexual activity or adolescent pregnancy and thus, has no single programmatic response to alleviate the associated problems. As evidenced in this report, a number of actions must be initiated in concert. In order to implement these actions, state and local government, religious groups, civic and community organizations, public and private agencies, health care systems, business and labor, and families and individuals must be mobilized to address the problems and crises of adolescent pregnancy in an open and aggressive manner.

The Economic Impact of Teenage Pregnancy

Teenage childbearing cost the United States \$16.6 billion in 1985, according to a study by the Center for Population Options. The 513,000 babies born to teen mothers in 1985 are expected to receive \$6 billion in public assistance benefits over the next 20 years in the form of Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps. This figure does not include the cost of education, special medical problems related to premature and low birth weight children, and the cost of housing, recreation, and transportation.

Using these national figures to project the cost of teenage childbearing in Mississippi, the task force projected that the 9,298 babies born to teens in 1984 would cost the state approximately \$332 million or \$35,700 per child.

This figure represents only the beginning of the economic burden placed upon the state. Over 70 percent of the mothers who first gave birth at ages 15-17 receive public assistance and these mothers are more likely to receive public assistance for longer periods of time; the average length of time has been estimated to be 10 years for those who start families as teens, are unmarried, nonwhite, and who drop out of school. For those teen mothers who do receive public assistance, it is estimated the first baby will receive \$15,620 prior to age 20. In 1985, and in each successive year, Mississippi will add an additional \$125 million of fiscal responsibility and burden to its already stressed budget.

While it is hard to place a dollar amount on the cost of a girl dropping out of school, comparisons in income levels between those girls with a four-year high school education and those who did not complete high school show that the dropouts earn an average of \$2,608 less annually. During the 1984-85 school year, 432 Mississippi girls gave pregnancy as the reason they quit school. Using these figures, it

can be projected that the pregnant girl who drops out of school and never returns will earn \$127,792 less over an estimated 49 years of working. Projecting the lifetime reduced income by the 432 girls who dropped out of school due to pregnancy, the state is facing a potential reduction in tax base of more than \$55 million for that one year's dropouts or an estimated \$5.06 million in revenues to the state's general fund.

Babies born to adolescent mothers are twice as likely to die before their first birthday as babies born to mothers aged 20 - 29. Three times the number of babies who die live with permanently handicapping conditions, many of which could have been prevented. It costs the state an estimated \$955,550 to provide a lifetime of care for one severely handicapped child.

Additionally, teen pregnancy today has negative implications for tomorrow's retirees. The financial contribution of today's adolescents will become even more important as our population as a whole grows older. In 1950, there were 17 workers contributing to the benefits of each Social Security recipient. Estimates are that as soon as 1992 and certainly by the year 2000, there will only be three workers.

Nearly half the children in Mississippi under six have mothers who work outside the home. For these 147,000 children, there are only slightly more than 70,000 licensed day care slots. The increasing demands that 9,000 additional teen pregnancies will place upon the child care facilities in Mississippi will soon create an insurmountable problem that will be reflected in the inability of many mothers to find adequate care for their preschool children and, therefore, reduce the options that many mothers will have in seeking employment or advancement.

Nearly one-third of the children in Mississippi were living below the poverty level when the 1980 Census information was collected. At least *one-third of all births in Mississippi* occur to poverty level or low income women and if the number of deliveries for which hospitals are unable to collect were considered, the percentage would be 48 percent.

The economic burden of children in poverty and of children having children cannot be underestimated nor can the need for the state to

vastly increase public assistance to those children of teenage mothers who are unable to provide either sufficient income or child care arrangements. The impact of adolescent mothers bearing children will have long-term negative effects on our state. Until serious consideration is given to this problem by those with the power to develop and fund programs aimed at reducing the number of children born to teens, the economic condition of the state will continue to be critically and negatively impacted.

Teenage Pregnancy Rate*
By County, 1984

County	Rate	County	Rate
STATE	62.2		
Sharkey	114.9	Simpson	62.5
Humphreys	106.0	Lee	62.3
Sunflower	98.4	Alcorn	61.7
Bolivar	97.9	Kemper	61.7
Washington	92.0	Jefferson	61.5
Tunica	91.5	Jones	61.0
Tallahatchie	90.8	Wilkinson	60.8
Issaquena	87.8	Monroe	60.0
Coahoma	86.6	Clay	59.7
Holmes	85.6	Marshall	59.5
Scott	85.0	Benton	57.7
Winston	82.4	Forrest	57.5
Yazoo	80.2	Chickasaw	57.2
Grenada	79.6	Lincoln	56.5
Panola	77.8	George	56.0
Clarke	75.4	Pontotoc	56.0
Noxubee	74.7	DeSoto	55.7
Leflore	74.5	Lawrence	55.6
Quitman	73.3	Neshoba	55.4
Covington	71.4	Tippah	55.4
Lauderdale	70.3	Jefferson Davis	55.3
Marion	67.8	Rankin	54.4
Leake	66.6	Adams	54.2
Jasper	66.4	Amite	54.2
Wathall	66.3	Greene	54.0
Montgomery	66.0	Newton	54.0
Warren	65.6	Pearl River	53.5
Madison	65.5	Smith	53.5
Hancock	65.2	Lowndes	53.0
Hinds	65.2	Lafayette	51.0
Attala	65.0	Union	50.7
Calhoun	64.9	Prentiss	49.0
Harrison	64.9	Lamar	46.8
Pike	64.7	Itawamba	46.1
Franklin	64.5	Jackson	44.7
Webster	64.3	Tate	43.8
Copiah	64.1	Tishomingo	42.0
Yalobusha	63.8	Oktibbeha	40.2
Perry	62.7	Stone	40.2
Wayne	62.7	Claiborne	36.5
Choctaw	62.6	Carroll	35.7

*Pregnancies Per 1,000, Female Population Aged 13 - 19.

Source: Mississippi State Department of Health
Public Health Statistics

Family and Youth Awareness and Responsibilities

While the task force recognizes teaching morals and values is a traditional family responsibility, changes in family structure, values and the economy have affected families and their abilities to perform some functions.

One measure of the changes in families is the number of single-parent families. In 1980, over 19 percent of families in Mississippi were headed by single parents and one in six Mississippi children under age 18 lived in a family headed by a single mother. Nearly 17 percent or 106,659 households were headed by females in 1980; in 1970, 70,924 families were headed by females. In 1960, the information on single-parent families was not even gathered by the Census Bureau.

The number of mothers who work outside the home also reflects changes in society and the economy. The Children's Defense Fund reports in a 1985 State Child Care Fact Book entitled "Child Care: Whose Priority?" that 54 percent of Mississippi mothers with children under age 6 work outside the home and 63 percent of Mississippi mothers with children ages 6 to 17 work outside the home. More than 244,000 or 30 percent of the children in the state live in poverty. Of these, 77,110 are under age 6. More than 45,000 or 42.5 percent of families headed by females are living below the poverty level in Mississippi.

The family environment is the first foundation in a child's life planning development. Positive self-esteem is viewed as a key to a child's successful ability to make decisions to his advantage and in processing the necessary information to deal with the world around him.

The nature of the adolescent must be taken into consideration in addressing problems of early sexual involvement and possible pregnancy and parenting. Biological maturation is only one of the dramatic events occurring during these

years which are often turbulent. The teen is also faced with a major psychological quest — one for personal identity. This is a time of increased dependency on peers and the struggle to become independent of family. As a part of both these processes, teens, in their effort to be a part of their peer group and to reassure themselves that they are "normal," begin to exhibit behavior which often results in conflict within the family.

This conflict or rebellion may become confused with parental values and cause the adolescent to question and appear to reject those values. Several studies have indicated that sexual activity is often viewed as a form of rebellion against parental values and is more likely to occur as an act of rebellion in families where the parents are uneasy, anxious, and threatened when faced with sexual matters. Other explanations involving the rebellion concept are that, for the adolescent girl, becoming pregnant and having a child is a sure method of attaining independence; some adolescents may use sexual activity and/or pregnancy as a means of seeking love and support which may be lacking in their home environment.

Families in which communication is open, where there is no abuse, and where there is generally a healthy, happy parent-child relationship are at less risk for premature, non-marital sexual relationships.

Societal double standards concerning sexual activity for male and female continue to play a role in the level of responsibility assumed by teens. Greater emphasis must be placed upon both male and female responsibility for sexual activity.

Attention must be given to the "latchkey" syndrome or the lack of supervision for some children and teens. An apparent lack of organized activities can be a contributing factor to undesirable behavior in teens. Young people

who are unsupervised after school and during the summer are more susceptible to negative influences and may begin to fall behind in their school work. Supervised after-school enrichment programs greatly benefit children who may be falling behind in class work.

In order for teens to begin successful preparation for entering adulthood, they must be equipped with self-motivation, positive self-esteem, employment skills, self-sufficiency, and rational decision-making skills.

The task force recognizes the importance of

parent-child communication and urges parents to become better educated in how to talk with their

Societal double standards concerning sexual activity for male and female continue to play a role in the level of responsibility assumed by teens.

children and in learning about their children's development.

The Task Force Recommends:

- Families and communities make greater use of the seminars developed jointly by the March of Dimes and the National Congress of Parents and Teachers entitled "Communications with Our Children: Seminars for Parents on Adolescent Sexuality" available from the state PTA office, Post Office Box 1946, Jackson, Mississippi 39205 or 352-7383.
 - Parents support the development of a curriculum for teaching comprehensive health education at all grade levels in the public school systems.
 - Parents be involved in the implementation of the health curriculum in the local school systems.
-
-

Community Awareness and Responsibility

Community means more than family and neighbors, organizations and clubs, and church and school. It includes the media, government, service agencies, public and private institutions, businesses and advertisers, and societal leaders. It involves all of these people and it requires acceptance and assumption of responsibilities. Partnerships among and between these people and groups are essential to prevention of unintended pregnancy and in assisting those families who face unintended teen pregnancies.

While many good things are happening in communities throughout Mississippi, there is an awareness problem concerning the issue of teen pregnancy and whose problem it is. **Existing service providers** hold responsibility for addressing the needs of teens through health care, education and other services. In addition, strategies must be developed to help teens learn to take responsibility for their futures by giving them reasons to accept responsibility and reasons to dream about their future. Strategies must also include expanding opportunities for career and educational choices while strengthening decision-making skills, rewarding hard work and encouraging responsible behavior.

The community must serve as an ancillary support to the family in meeting its responsibility and in some cases assume responsibility where the family is neglectful or unable to meet its responsibility.

While all teenagers can be said to be at risk of becoming parents, studies show that one-third of teenage girls will have experienced a pregnancy before their 19th birthday. These teens, who are more at risk, must be identified at the community

level and community resources must be coordinated to serve them.

Strategies must be developed to help teens learn to take responsibility for their futures by giving them reasons to accept responsibility and reasons to dream about their future.

Civic organizations, both those serving youth and adults, play an important function in the community as potential guides to young people in life planning stages. Many of the adult organizations in communities conduct service projects directed toward youth and have crucial roles in providing role models for young people, shaping values and in activating the community. Organizations should conduct a needs assessment in their communities and look at such areas as after-school and summer programs and activities for youth; sponsor learning centers and extracurricular activities designed to bolster the self-esteem of young people; offer job option training and awareness; and accept the responsibility of assisting in the life planning of young people by enhancing the teen's ability to become self-sufficient.

The **local media** must also accept its responsibility in shaping the lives of young people. Many of the role models depicted in the media, through advertising, entertainment and reporting, are poor and contradictory to responsible and acceptable values. The conflicting messages teens receive are at best confusing. The entertainment industry, advertisers, and the advertising industry play a significant role in the community and in the direction of life planning for many teens. Local advertisers and media also have a crucial role to play in community

involvement by addressing the issues of values and family and in calling for community responsibility.

Churches and synagogues have traditionally played a major role in shaping family and community values. In order to increase this role, churches and synagogues will have to increase their partnerships with secular groups and enhance family communications by addressing necessary issues for teen life planning. Many denominations have materials available for local church and synagogue use through district or state offices. For example, the Mississippi Baptist Convention office has available a curriculum entitled "Christian Sex Education: A

Resource Packet" and resource people available to conduct seminars and workshops on sexuality.

Community leadership includes, but is not limited to elected, societal and public-opinion leaders. The leaders of a community, by their example, their commitment and their focus on the life planning stages of youth can have great impact in development of positive goals and support for families and teens. In partnership with all available community resources, community leaders can identify the needs of their communities from a new angle and establish activities to meet those needs.

Recommendations:

- **Service providers in communities should coordinate their resources in addressing strategies for the prevention of adolescent pregnancies and in identifying adolescents locally who are at greater risk than other youth for becoming parents.**
 - **Civic organizations should conduct needs assessments to identify and develop activities for youth in their communities.**
 - **Local media and advertisers should use their editorial powers and public image to enlighten and to motivate their communities into action to address these issues.**
 - **Churches and synagogues should determine what resources are available through their denominational headquarters for use with young people and utilize the materials. For example, a resource packet is available on Christian Sex Education from the Mississippi Baptist Convention Board, Post Office Box 530, Jackson, Mississippi 39205.**
 - **When appropriate resources are not available, churches and synagogues should develop materials suitable for use with young people and share that material with other churches and synagogues.**
-

Health Issues of Adolescent Pregnancy

While the task force recognizes that pregnancy prevention is the ideal focus for family and community, we also acknowledge the existing problem and in this section address primarily the health issues of the pregnant teen, her baby and family.

The **emotional health** aspects of pregnant and parenting adolescents are often overlooked in the seemingly larger needs of physical health, but the emotional consequences of adolescent pregnancy are numerous and involve the pregnant girl, her child, the father and the parents of the adolescent(s).

The adolescent who becomes pregnant is first confronted by the traumatic decision of whether or not to have the baby and, if she decides to have the baby, whether to keep the baby or to allow the baby to be placed for adoption.

The pregnant girl must face separation from her peers at a critical period of socialization in her life. She must prematurely begin life planning for herself and her child, accepting responsibilities in decision-making far beyond her level of emotional development. Her concerns must center around continuing her education, possibly modifying her career goals, planning her financial support, finding infant and child care, and repairing family relationships which are often damaged by adolescent sexual activity and pregnancy.

The father of the child may be a teenager himself with incomplete education and lack regular or adequate income. Informal findings from programs in Mississippi serving pregnant adolescents, however, indicate that often the fathers are older teens or young adults. An Urban Institute study reports that half the babies born to teens are fathered by men over 20. The father of the child also has choices to make which include supporting the child financially or

denying responsibility for the child. The percent of the teen births that were out-of-wedlock in 1985 in Mississippi was 67 percent compared to 55 percent nationally in 1983, the most recent figure available. Forty-four percent of all the babies born out-of-wedlock in 1985 in Mississippi were born to teens. Of those teens who do marry while pregnant, about 60 percent divorce within six years.

The baby also faces immediate problems including the likelihood of premature birth, low birth weight and possible handicapping conditions, as well as later emotional problems. Studies indicate that children born to teen parents are likely to have problems adjusting to school and often demonstrate behavioral disorders and are more likely to have lower intelligence quotient and to repeat at least one grade in school. Research also shows that children born to teenage mothers often demonstrate hostility, are easily frustrated, and can be uncommunicative and overly conforming. Researchers point out that other conditions including poverty, low birth weight and poor nutrition may also contribute to these problems. Recent local events have also pointed to children of female single heads of households attempting to compensate for the lack of male role models through gangs. Nicholas Lemann, quoted in the July 13, 1986 edition of "The Clarion-Ledger/Jackson Daily News," said, "A large number of fatherless families, a high unemployment rate for black teenagers—these are ideal conditions for gangs to develop." The article also stated that "a gang leader may be a father-like figure" and that gangs often give these youths a needed sense of identity and family structure that may be missing in their homes. Teen parents are more likely to abuse and/or neglect their children than older parents.

The pregnant adolescent's parents must often bear much of the financial responsibility of the pregnancy and assist the adolescent in making arrangements for the delivery of the baby. The

pregnant girl is often in a single parent family setting herself and may rely on her mother to a great extent for rearing the baby.

Recommendations:

- Individual and family counseling be provided for all pregnant teenagers which includes parenting instruction, health care both during and after pregnancy, resolution of guilt and ambivalent feelings, low self-esteem, education and employment goals, financial services and support, and family planning discussion including effective contraception.
 - Counseling and guidance services be provided for the young fathers with emphasis on more responsible sexual practices, assumption of financial responsibilities, and resolution of guilt and ambivalent feelings.
 - Group or individual counseling be provided for the families of pregnant adolescents to encourage their emotional support of the adolescent.
-

With early and continuous prenatal care, the immediate health problems of the mother and baby can be decreased. Premature delivery and toxemia are the two complications of teenage pregnancy which occur in higher incidence regardless of the prenatal care provided. If the

adolescent receives good health care, the rate of all other complications are no higher than in older pregnant women. Early prenatal care depends upon early diagnosis of the pregnancy and easy access to medical care.

Recommendations:

- Adolescents be educated to the symptoms of pregnancy and the importance of seeking medical diagnosis and care when pregnancy is first suspected. Emphasis must be placed upon confidentiality and promise of health benefits from early medical care in pregnancy. Warm and supportive medical and nursing personnel are essential and special attention must be given to the important rules of self-care.
 - The State Medical Association and the State Department of Health combine resources to conduct seminars for physicians, nurses, and midwives on the special needs of teenage mothers, emphasizing the importance of nonjudgmental attitudes in all professionals in order to further encourage cooperation from the patient.
 - Adolescents be educated in methods of gaining access to the health care and social service system in their area, and then encourage their fullest use.
 - Comprehensive health education and services be provided statewide in school settings for health screening and referral that these services also include qualified counselors and/or social workers.
-

With proper access to medical care and adequate prenatal care, the **delivery** of the infant should present minimal risk to mother and child. The frequency of premature birth to

adolescent mothers requires the availability of facilities to care for high risk babies when the mother is under the age of 21 years.

Recommendations:

- Medical, nursing and certified nurse midwife personnel be educated on the importance of providing access to high risk care units upon delivery of high risk infants.
 - Expansion of high risk care facilities in a regional fashion in order that survival rates in teenage deliveries may be increased statewide.
 - The Governor's Office and the Legislature support one central source for perinatal education through the University of Mississippi Medical Center. Approval of any state or federal dollars statewide for perinatal education should stipulate coordination with University Medical Center and use of this common curriculum or protocol.
-

If any complications of adolescent pregnancy occur, immediate referral should be made to medical facilities providing full care for the high risk infant and mother. Careful followup

visits for **postnatal care** should be required and family planning education, including contraceptive counseling, should be included in postnatal counseling.

Recommendations:

- Medical personnel be educated on the importance of emphasizing personal values and priorities as deterrents to future pregnancies when counseling adolescents.
 - The young mother and father be educated in alternative methods of contraceptives, including abstinence from sexual intercourse as one birth control method.
 - Parenting education, including the growth and development stages of the child, be provided.
 - A follow-up system be established which supports positive goals for the future and utilizes all available agencies and appropriate individuals.
 - The establishment of school health services at all levels of public schools. These services can be as comprehensive as a full health screening and referral clinic or as basic as a nurse and trained counselor/social worker.
 - Professional organizations in the health fields accept the responsibility of assuring access to medical care on the local level and identifying the current levels of access for adolescents.
 - Parenting support groups be established at the community level to aid the teen parent in caring for his/her child; to encourage the prevention of the second pregnancy; and to aid the teen parent in establishing a positive direction for the future.
-

Education

Education is more readily identifiable as the cornerstone in the life planning of a teen. Pregnant and parenting teens often find themselves off-track educationally and face obstacles in getting back into the educational system. Studies have also proved a direct connection between the rate of teen pregnancy and poor academic achievement. Adolescents with the poorest basic academic skills are five times more likely to have a baby before the age of 18 than those with average skills. Many school districts have recognized the benefits of alternative programs which also address the special needs of these teens.

Of the 11,608 students who dropped out of school in Mississippi in the 1984-85 school year, 432 cited pregnancy as the reason. One fifth grader, seven sixth graders, 25 seventh graders, 68 eighth graders, 89 ninth graders, 101 sophomores, 77 juniors, 50 seniors, and 14 unclassified students gave pregnancy as the reason they dropped out of school. Another 306 dropped out because of marriage while nearly 3,500 dropped out for unknown reasons.

While it is hard to place a dollar amount on the cost of a girl dropping out of school, comparisons in income levels between those girls with a four-year high school education and those who did not complete high school show that the dropouts earn an average of \$2,608 less annually. During the 1984-85 school year, 432 Mississippi girls gave pregnancy as the reason they quit school. Using these figures, it can be projected that the pregnant girl who drops out of school and never returns will earn \$127,792 less over an estimated 49 years of working.

Comprehensive health education has been a goal of the task force since its inception and with the leadership of advocacy groups, state agencies, and key legislators, the Board of Education approved the development of a

curriculum. A task force was appointed by the Superintendent of Education in May 1986 to begin the curriculum development. The Adolescent Pregnancy task force will be represented on this Education Department task force.

Statistics show that more adolescents are getting pregnant at earlier ages, many without knowledge or understanding of the consequences of their actions. Studies by the Guttmacher Institute, comparing the teen pregnancy rate in the United States with other countries, have shown that U.S. teens are not more sexually active, but less likely to use contraception. Education and the availability of contraception are reflected in teen pregnancy rates of the countries studied. The U.S. teen pregnancy rate far surpasses the rate of other nations of the Western world.

With a clear understanding of good health practices, encouragement to postpone sexual activity, personal responsibility for healthy life planning and clear reasons to delay parenthood, teens will have a clearer concept of the consequences of sexual activity and possible pregnancies to their futures. Special attention should be given to the teen male and his need for information and life planning goals.

The function of school counselors is currently perceived as strictly academic, testing and working with college-bound students. Students need a trained professional who can work with them in all phases of life planning using a case management approach to the real problems many students now struggle with alone. The school is the single institution in contact with the largest number of children and youth in the state and is the institution with the most opportunity and potential to impact on children in Mississippi.

Programs which work specifically with pregnant and parenting teens in job-training are necessary in the existing educational system.

Research cited in the Children's Defense Fund Budget Analysis for FY '87 indicates that "teens from low income families, regardless of race — teens with poor basic skills and poor employment potential — face higher risks of

The school is the single institution in contact with the largest number of children and youth in the state and is the institution with the most opportunity and potential to impact on children in Mississippi.

early parenthood." The same document also says, "...too many of America's poor and minority youths who have no hopes for better futures become parents too young because they do not think they have anything to lose."

In Mississippi, the Department of Job Development and Training which administers funds of the Job Training Partnership Act (JTPA) has made teen parents a target group and sponsors two programs exclusively for teen parents which combine job training with educational attainment.

Alternative education programs can play a significant role in helping pregnant and parenting teens stay in school. Programs often incorporate instruction in the health care needs of pregnant teens and parenting training as well as continued academic courses to allow the teen to keep pace with course work. Some programs

combine day care features with job training and parenting skill courses.

The Hattiesburg Alternative Program provides alternative education to pregnant students through regular school funding, while the Jackson-Hinds Comprehensive Health Center is funded through both federal and foundation grants and provides comprehensive health care to students in five junior high and high schools. Infant and child day care programs are provided so that the student/parent can continue her education. The MACE Teen Parent Center in Greenville works to help the pregnant and parenting adolescent continue her education, develop employment and parenting skills, delay subsequent pregnancies and ultimately achieve economic and personal self-sufficiency. The Teen Learning Center in Meridian provides short-term instruction to help prevent students from dropping out of school during stress periods, including pregnancy and parenthood. There are other programs in the state, many of which are listed in the task force's "1985 Survey: Mississippi Services to Pregnant and Parenting Teens."

Few parents, teen or adult, receive formal training for the important function of parenting. Teen parents are at greater risk to become neglectful and/or abusive. Training and support of their role as parents are essential elements in the life planning development of both the teen parent and the child.

Recommendations:

- Teens who are sexually active and at high risk for becoming parents and for dropping out of school need trained professionals to work with them in all phases of life planning in a case management approach.
- Schools establish academic remediation programs at elementary and junior high levels to avoid academic failure which often leads to dropping out, to premature sexual activity and pregnancy.

- Alternative educational programs are needed to help pregnant and parenting teens complete their education.
 - Job training programs directed at pregnant and parenting teens be established to help them reach their fullest potential and to be able to support themselves and their child.
 - Day care be available for those teen parents who are in school, job training, or working.
 - Parenting training is essential for teen parents to provide optimal environment for their children.
 - Schools or communities implement an interdisciplinary approach to working with pregnant and parenting teens which includes social workers, counselors, and teachers, as well as traditional health care personnel.
-

Support Services

A 1985 survey of services and programs in Mississippi geared to pregnant and parenting teens revealed that services are inadequate and unevenly distributed throughout the state and that existing programs have no network through which to exchange information. There is little or no coordination through support services to identify teens who are at risk, and while there are numerous services and programs available to the general teen population, these services are not linked in any way.

The single, most effective contact with young people in this age group is through the school setting. According to the task force's "1985 Survey: Mississippi Services to Pregnant and Parenting Teens," existing **in-school clinics**, serving the complete health needs of teens, have proved to be extremely successful in identifying at risk teens, in preventing unintended pregnancies and in reducing repeat pregnancies. In-school clinics also have the capabilities and responsibilities to begin early parenting education, to provide information to pregnant teens and to encourage realistic life planning for the teen and her child. School-based clinics are the nearest thing to coordinated case management for teens, and these clinics exist in only one school district in the state.

In pilot projects coordinated by the Departments of Health and Education, **school nurses** in junior high schools provided classroom educational sessions, individual education and counseling, physical assessments and referrals. The project, in eight junior high schools, was directed to encouraging the postponement of sexual involvement by teens and, for the sexually active teen, the prevention of unintended pregnancies. Preliminary indicators are that the number of pregnancies in students decreased significantly. Sixty teens are enrolled in family planning services and 25 documented cases of

sexually transmitted diseases were referred for treatment. The five nurses in the project made over 17,000 student contacts and conducted over 2,000 personal counseling sessions in a student population of 4,000.

Proper nutrition for the pregnant teen and her child are vital to healthy starts. Teens are more likely to give birth to low birth weight babies, who are 20 times more likely to die within their first year of life. Low birth weight also contributes significantly to mental retardation and other serious health problems. The age of the mother, lack of prenatal care, poor nutrition, low education and socio-economic status, smoking, alcohol and drug abuse are associated with low birth weight.

The WIC program, a Special Supplemental Food Program for Women, Infants, and Children, is designed to meet the nutritional needs of pregnant women and their children. A five-year study documented increased birth weight and brain growth among infants born to WIC participants and children directly benefiting from WIC. In Mississippi, infant mortality rates among WIC participants dropped by one-third, and the number of premature births decreased as much as 25 percent.

Financial and medical aid to pregnant and parenting teens is critical to the health of both teen and child. Thirty percent of Mississippi's children were living below the poverty level according to information gathered during the 1980 Census. The poverty level set by the federal government for 1985 was \$8,850 for a family of three.

In January 1985, the combined benefits in Mississippi represented 41.1 percent of the poverty level or \$303 per month for a family of three. According to information from the Children's Defense Fund '87 Budget Analysis, in January 1985, Mississippi ranked last in

monthly AFDC and food benefits as a percentage of monthly 1985 federal poverty level. One month's AFDC payments in Mississippi totaled \$698,148 in April 1986. This assistance went to 9,873 children in the state in 7,447 households. No information is available on how many of these households are headed by teen parents; however, many of the pregnant and parenting teens are reflected in the 9,873 children who received assistance. Current assistance rates are \$60 for the first child, \$36 for the second child and \$24 for each additional child with the parent or guardian also receiving a \$24 allotment.

Effective July 1, 1986, the standard for determining eligibility for AFDC/Medicaid and for Medical Assistance was increased to 50 percent of the poverty level. The Medical Assistance program provides prenatal and delivery services to pregnant women and outpatient and inpatient care for their children up to age 18. It is available to any pregnant woman, married or unmarried, who meets the income criteria and to children in a low-income family and children of a teenage parent. In order to qualify, a family of three cannot have more than \$369 in monthly income as of July 1 — that's an increase from \$286. Children of teenage parents need only count the parent's income, not their grandparents', to qualify. In June 1986, 6018 children and 798 pregnant women received assistance through the Medical Assistance program. Under new federal legislation, Medicaid is now mandated to cover all pregnant women with family incomes and resources below the state AFDC financial eligibility levels; an additional 60 days post-partum coverage is provided for all women whose Medicaid eligibility is based solely on pregnancy, even if they would not otherwise be eligible for Medicaid once their pregnancies end. In addition, any Medicare-funded hospital facility is prohibited from refusing to treat, or appropriately transfer, emergen-

cy patients including those in active labor. This law also permits states to provide pregnant women with enriched Medicaid benefits. Studies show that more comprehensive Medicaid benefits during pregnancy lead to better birth outcomes and reduced Medicaid costs.

National statistics show that teen mothers are more likely to receive public assistance later in life. Approximately 72 percent of the mothers who first gave birth at ages 15-17 are receiving public assistance. A soon-to-be published study by a sociologist at the University of

The offspring of teenage childbearers are doing substantially worse academically, emotionally, and socially than the children of women who had their first child after age 20.

The adolescent mothers in the study who participated in health care and family planning services combined with a high school program involving instruction, counseling and child care education were substantially more likely to avoid welfare dependence and limit their family size in later life.

Pennsylvania indicates that teen mothers often recover socially and financially to a much greater extent than is commonly expected. While they face great disadvantages compared to women who have children later in life, sociologist Frank Furstenberg's study, which followed the progress of 300 black, adolescent mothers from Baltimore and their children for 17 years, shows that many manage to overcome these obstacles through three significant

ways: pursuing their education, limiting the births of subsequent children, and achieving a stable marriage. The study found, however, that the children of these adolescent mothers often demonstrate serious adjustment problems in their teen years. "The offspring of teenage childbearers are doing substantially worse academically, emotionally, and socially than the children of women who had their first child after age 20," the report says.

"The adolescent mothers in the study who participated in health care and family planning services combined with a high school program involving instruction, counseling and child care education were substantially more likely to avoid welfare dependence and limit their family size in later life," Furstenberg said.

Recommendations:

- Comprehensive planning among private and public agencies and professional health organizations be coordinated to address the short-term and long-range needs of adolescents for postponement of sexual activity, for prevention of pregnancy among those who are sexually active and services for those who are pregnant and/or parents.
 - The State Department of Public Welfare actively seek available federal funds for maternity services for teens in addition to those currently available through AFDC/Medical Assistance/Medicaid.
-

Summary

Services currently being offered to at-risk teens, pregnant teens and parenting teens are inadequate and unevenly distributed in the state and there is no network for existing programs to exchange information. Few of the programs are designed comprehensively or specifically to meet the special needs of teenagers.

The existing services, public and private, are not linked for referral or coordination. Case managers are not available to teens. There is no systematic approach to identifying teens at risk of becoming sexually active and/or pregnant. Random attempts are made in the Early and Periodic Screening Diagnosis and Treatment program or in family living courses through Home Economics curriculums in most high

schools to provide basic reproductive information to teens.

A core service support system which would work to identify at-risk teens; provide services to those teens as well as to pregnant, parenting teens and their families; and provide complete services for life planning through a case management approach will require great coordination and support within the service delivery system and is essential to ameliorating this problem in Mississippi.

Leadership will have to be provided from all arenas and from all levels if Mississippi is to break the disruptive cycle of children having children.

Bibliography

"Teen Childbearing Cost \$16.6 Billion," *The Clarion-Ledger*, February 19, 1986, p. 4A.

Estimates of Public Cost for Teenage Childbearing: A Review of Recent and Estimates of 1985 Public Cost, Center for Population Options, Washington, D.C.

State Department of Health; Bureau of Labor and Statistics; 1980 Census.

Mississippi Research and Development Center, 1980 Census; U.S. Department of Housing and Urban Development; "The Financing of Prenatal Care Provided by Mississippi Hospitals," Mississippi Hospital Commission, 1984.

Maternal and Child Health Data Book: The Health of America's Children, Adolescent Pregnancy Prevention: Prenatal Care Program, Children's Defense Fund, Washington, D.C., 1986.

A Children's Defense Budget, An Analysis of the FY 1987 Federal Budget and Children, Children's Defense Fund.

Report and Recommendations on Infant Mortality in Mississippi, Commission for Children and Youth, Governor's Office of Federal-State Programs, November 1985.

"The Status of Children in Mississippi," Commission for Children and Youth, January 1985.

Child Care: Whose Priority? A State Child Care Fact Book, 1985, A White Paper prepared by Helen Blank and Amy Wilkins, Children's Defense Fund.

"Vital Statistics, Mississippi, 1984," Mississippi State Department of Health, Office of Public Health Statistics.

Donnelley Demographics adapted by MSU Department of Sociology and Anthropology and Mississippi Cooperative Extension Service.

"School Dropouts by Reason, 1984-85," State Department of Education, Bureau of Administration and Finance, Jackson, Mississippi.

The Network, The Newsletter of the North Carolina Coalition on Adolescent Pregnancy, Spring, 1986 "Furstenberg Research Follows Teen Mothers for 17 Years."

"1985 Survey: Mississippi Services to Pregnant and Parenting Teens," Commission for Children and Youth, Governor's Office of Federal-State Programs.

"Prevent Children Having Children," Clearinghouse Paper Number 1, Children's Defense Fund.

A Report on the Activities of the Select Committee on Children, Youth, Families, U.S. House of Representatives, Ninety-ninth Congress, Second Session, 1986.

Reducing Poverty Among Children, Congress of the United States, Congressional Budget Office, May 1985.

"Teenage Pregnancy," Martha R. Burt, Ph.D. Presentation prepared for the National Conference of State Legislatures conference, "Children in Poverty: The Effects of Nonsupport," October 1985, Charleston, South Carolina.

University Medical Center, Social Work Department, Jackson, Mississippi.

"A Call to Action," Final Report, Governor's Task Force on Teen Pregnancy, State of Maryland, September 1985.

Medical Assistance Task Force, Jackson, Mississippi.

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

**1983 Percentages
Low Birth Weight* Babies**

	United States	Mississippi	Mississippi Rank Among States
All Low Birth Weight Babies	6.8	8.8	50 of 51
White	5.7	5.9	33 of 51
Non-White	11.4	11.9	32 of 48***
% of All Teen Mothers Having Low Birth Weight Babies	9.5	11.3	48 of 51
White Teen Mothers	7.8	8.1	36 of 50**
Non-White Teen Mothers	13.4	13.2	15 of 40***
% All Low Birth Weight Babies Born to Teens	19.2	27.4	50 of 51
White	16.1	22.2	44 of 50**
Non-White	25.2	30.7	37 of 40***

* Low Birth Weight — Under 5.5 pounds

** Excludes District of Columbia

*** Several states have a small number of non-white low birth weight births to teens and were not ranked.

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

**1983 Percentages
Teen Births Out-of-Wedlock**

	United States	Mississippi	Mississippi Rank Among States
All Teens	54.1	63.5	43 of 51
White	39.7	21.4	1 of 51
Non-White	85.7	88.5	34 of 48*

**1983 Percentages
All Out-of-Wedlock Babies Born to Teens**

	United States	Mississippi	Mississippi Rank Among States
All	36.6	43.7	49 of 51
White	36.6	47.5	51 of 51
Non-White	36.6	43.2	47 of 48*

* Because of small numbers, several states were not included in count.

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

**1983 Percentages
Women Receiving Early* Prenatal Care**

	United States	Mississippi	Mississippi Rank Among States
% of All Women and Teens	76.2	74.6	37 of 51**
White	79.4	85.1	7 of 51
Non-White	63.4	63.3	31 of 51
% of All Teens	53.8	57.3	19 of 51**
White	56.9	68.7	4 of 50
Non-White	46.8	50.5	20 of 48

* Prenatal Care in First Three Months of Pregnancy

** Includes District of Columbia

From: *Maternal and Child Health Data Book*
Children's Defense Fund, 1986

1983 Percentages
Women Receiving Late* or No Prenatal Care

	United States	Mississippi	Mississippi Rank Among States
% of All Women and Teens	5.6	4.6	28 of 51
White	4.6	2.5	9 of 51
Non-White	9.4	6.8	8 of 48**
% of All Teens	11.7	8.4	13 of 51
White	10.6	5.7	5 of 50
Non-White	14.1	10.0	6 of 44**

* Late prenatal care refers to starting prenatal care in last three months of pregnancy

** States with very small numbers of non-white births are not ranked

From: Mississippi Department of Health

**1983 Percentages
Low Birth Weight to Teens**

Age of Mother	% of Low Birth Weight Infants
15	16.2
15 - 17	12.2
18 - 19	10.5
20 - 29	8.3

In 1984, statistics released by the State Department of Health show that in Mississippi births to teens represent 21 percent of total births.

**Teen Births By Age and Race
1984**

AGE	WHITE	NONWHITE	TOTAL
11	0	2	2
12	0	14	14
13	7	72	79
14	27	286	313
15	135	519	654
16	349	940	1,289
17	615	1,131	1,746
18	912	1,404	2,316
19	1,248	1,637	2,885
TOTAL	3,293	6,005	9,298

Source: Mississippi State Department of Health
Public Health Statistics

Adolescent Pregnancy Task Force Members

Mrs. Martha Stennis Chair

Ms. Doris Barnett	Ms. Betty Jo Hines	Ms. Marion Jones
Ms. Sandra Huckaby	Citizen	Commission for Children
Mississippi Department of Health	Greenville	and Youth
Jackson	Ms. Anne Phelps	Jackson
William Long, Jr., M.D.	Virginia Mounger, J.D.	Ms. Barbara Brown
Mississippi Academy of Pediatrics	Junior League of Jackson	Mississippi Action for Community
Jackson	Ms. Janice Sandefur	Education
Sister Mary Murphy	Ms. Linda West	Greenville
Catholic Charities	Mississippi Children's Home	Phillip Rhodes, M.D.
Jackson	Society and Family Service	University Medical Center
Ms. Liz Peeler	Association	Jackson
Mississippi Congress of Parents	Jackson	Wood C. Hiatt, M.D.
and Teachers	Ms. Velma Tate	Child Psychiatry
Jackson	Mississippi Coalition for Mothers	Jackson
Lucy Leslie, Ph.D.	and Babies	Ms. Carol Blackmon
Mississippi Department of	Jackson	Children's Defense Fund
Mental Health	Ms. Shirley Haggard	Jackson
Jackson	Cathy Grace, Ph.D.	Wendell Stockton, M.D.
Ms. Martha Gullede	Mississippi Department of	Commission for Children
Mississippi Department of	Education	and Youth
Public Welfare	Helen Barnes, M.D.	Amory
Jackson	Mississippi Obstetrical/Gynecological	Ms. Daisy Cobbins
Geraldine Brookins, Ph.D.	Society	Mississippi Congress of Parents
Planned Parenthood, Mississippi	Jackson	and Teachers
Chapter	George Ball, M.D.	Jackson
Jackson	Mississippi Section, American	Mr. Ed Smith
Paul Jones, Ph.D.	College of Obstetricians and	March of Dimes
Mississippi Baptist Convention Board	Gynecologist	Jackson
Jackson	Jackson	Mr. Robert Walker
Aaron Shirley, M.D.	Ms. Brenda Sumrall	Citizen
Mississippi Medical and Surgical	Mr. Mike Gallerno	Vicksburg
Association	National Association of Social	Ms. Linda Ross Aldy
Jackson	Workers, Mississippi Chapter	Commission for Children
Ms. Charlotte C. Christ, ACSW	Jackson	and Youth
Mississippi Department of	Ms. Judy Foster	Staff to Task Force
Mental Health	The Clarion-Ledger	Jackson
Jackson	Jackson	